Birchwood Surgery

Additional Medical & Personal Information Pack

(This is not your registration form. Please see inside for further details)

CHILD (< 16)

Welcome to Birchwood Surgery

Thank you for choosing us to be your family Doctor

What you need to do next :

1. Be aware that **ALL** patients must also fill out the GMS-1 form which can also be found on our website
2. Please obtain your NHS number from your previous GP practice if this is applicable before attending your registration appointment.
3. Contact the surgery to book in a registration appointment.(this is not currently required due to the Covid-19 Pandemic)
4. Complete all forms as thoroughly as possible and if possible attach a copy of your repeat prescription side slip if this is applicable.
5. Bring the completed forms and the required two (2) pieces of evidence (see list below) back to the surgery reception team.

Check List for proof of ID

Photo ID X 1		Proof of Address X 1	
Childs Red Book	☐	Tenancy agreement	☐
Passport	☐	Bank Statement	☐
European ID Card	☐	Utility Bill	☐
		Maternaty Discharge Letter	☐

BIRCHWOOD SURGERY

Privacy Notice

We Understand how important it is to keep your personal information safe and secure. We have taken steps to make sure your personal information is looked after in the best possible way, and regularly reviewed.

If you would like to know how we use the personal and healthcare information we collect on your behalf, our Privacy Notice can be found on our website or alternatively you can request a copy from main reception.

New Patient Registration Form (*Children: under 16s*)

Instructions for completing this form on behalf of a Child

Date: …….

1. Complete a separate form for each child to be registered
2. Complete in **BLOCK CAPITALS** and tick the boxes and fill in each section as appropriate

1	**Full Name:**	**Home Telephone Number:**
	Title : ☐ **Master** ☐ **Miss**	**Mobile Telephone Number:**
	Other. *Please state* **:**	**A contact telephone number will be required to complete the registration**
	NHS number if known:	We will automatically use this number to send appointment reminders and health promotion details. If you do not wish to receive reminders and health promotion details. Please tick here to **Opt out** of this service : ☐
	Address: **Postcode:**	**Next of Kin:**
	How would like us to contact you about your child: **Letter** ☐ **Email** ☐ **SMS (text)** ☐ **Phone** ☐	**Next of Kin Relationship to child:** **Next of Kin contact tel. number:**
	Date of Birth: **Gender:** **Male** ☐ **Female** ☐	**Mothers name:** **Mothers DOB:**
	Town* and Country of birth **(*If town is London please state which Borough)**	**Country:** **Town:** **Borough (*If born in London):**
	Please list other residents of your home who are registered with us:	**Name:** **Date of Birth:**

2	**Looking after a family member THIS SECTION MUST BE FILLED IN**	
	Is your child looking after someone? Let us know if your child is looking after someone who is ill, frail, disabled or has mental health and/or emotional support needs, or substance misuse problems	Yes ☐ No ☐
	Is the child looked after by someone other than the Birth Parents? (Foster parents, Carer, Adoptive Parents, Grandparents or other relatives.) **Please Specify……**	Yes ☐ No ☐
	Carers name:	
	Address of carer:	
	Telephone number for Carer: ☐☐☐☐☐☐☐☐☐☐☐	
	Is the child under a child protection plan? Please let us know if the child being registered is under the child protection register	Yes ☐ No ☐
	Is the child under a named social worker? (if Yes please provide name and contact number of social worker below)	Yes ☐ No ☐
	Name of social worker (if applicable):	
	Telephone number of social worker**:** ☐☐☐☐☐☐☐☐☐☐☐	

3							
	Your Child's Religion (Please tick)	C of E ☐	Catholic ☐	Other Christian (state): ☐	Buddhist ☐	Hindu ☐	Muslim ☐
		Sikh ☐	Jewish ☐	Jehovah's Witness ☐	No religion ☐	Other religion (state) ☐	
	Your Child's Ethnic Origin (Please tick one)	White (UK) ☐		White (Irish) ☐	White (Other) ☐		
	Black Caribbean / British ☐	Indian / British Indian ☐		Arabic ☐	Other Mixed Background ☐		
	Black African / British ☐	Pakistani / British Pakistani ☐		Chinese ☐	Other Asian Background ☐		
	Other Black Background ☐	Bangladeshi / British Bangladeshi ☐		Other ☐	Ethnic Category Refused ☐		
	What is your child's main spoken language? **Does your child speak English?** Yes ☐ No ☐			**Does your child need an Interpreter?** Yes ☐ No ☐			
	Does your child need help with mobility/hearing/speaking? (tick all that apply)						
	Wheelchair ☐	Walking aid ☐		Hearing aid ☐	British sign language (BSL) ☐	Makaton sign language ☐	
	Lip reading: ☐	Large print: ☐		Braille ☐	Other. ***Please state***: ☐		
	Is your child currently?	Homeless ☐		A Refugee ☐	An Asylum Seeker ☐		
	Is your child housebound?	Yes ☐ No ☐		Comments:			

Please state all countries your child has lived in or visited for periods of greater than 6 months:	
Country:	**Dates/Year (If known):**

4	**Online Services & access to your medical records**
	You can now do the following online or via the SystemOnline app: • Book and cancel appointments, • order repeat prescriptions, • View a summary of your medical record. • Medical coded record ▪ **IT WILL BE YOUR RESPONSIBILITY TO KEEP YOUR LOGIN DETAILS AND PASSWORD SAFE AND SECURE.** ▪ **IF YOU KNOW OR SUSPECT THAT YOUR RECORD HAS BEEN ACCESSED BY SOMEONE THAT YOU HAVE NOT AGREED SHOULD SEE IT, THEN YOU SHOULD CHANGE YOUR PASSWORD IMMEDIATELY.**
	Please Provide your Email Address:
	You will automatically be Opted in for online services, if you do not wish to be opted in for these services please tick the box to opt out. **I wish to Opt out of online services** You will automatically be **Opted in** for online services, if you do not wish to be opted in for these services please tick the box to opt out. I wish to **Opt out** of online services ☐

5	**Electronic Prescription Service**
	The Electronic Prescription Service **(EPS**) sends electronic prescriptions from GP surgeries to pharmacies. Eventually EPS will remove the need for most paper prescriptions. Please add your nominated pharmacy below. We will automatically send your prescriptions to your nominated pharmacy where possible **Nominated Pharmacy**…… Once you have selected a pharmacy, please ensure you advise the pharmacy that you have selected them to receive and request your repeat medications.

6	**Medical background**				
	Are there any serious diseases that affect your child's **parents, brothers or sisters**? Tick all that apply ***and*** state **family member**:				
	Diabetes ☐ Who:	**Asthma** ☐ Who:	**Thyroid disorder** ☐ Who:	**Stroke** ☐ Who:	**COPD** ☐ Who:
	Heart Attack under age of 60 ☐ Who:	**Cancer (Specify type)** ☐ Who:	**High Blood pressure** ☐ Who:	**Any other important family illness. *Please state*:** Who:	
	Please state any allergies and sensitivities that your child has to medicines, food & dressings:				
	Please state any mental disabilities your child has:				
	Does your child have any problems taking medicines?	Yes ☐ No ☐	***If yes*** please give details, e.g. swallowing		

What chronic medical conditions has your child had?	Date of Diagnosis:
What operations has your child had?	Date of operation/s:
What injuries has your child had?	Date of injury/s

Please list any tablets, medicines or other treatments you are currently taking / undertaking:

Name	Dose	Quantity/ How often	GP Prescribed?
1.			Yes/No
2.			Yes/No
3.			Yes/No
4.			Yes/No
5.			Yes/No
6.			Yes/No
7.			Yes/No
8.			Yes/No
9.			Yes/No
10.			Yes/No

Please remember that if you require repeat medication in the next week, please advise the registration clerk who will then book you a GP appointment.

New Born Only

Do you consent to having all childhood Immunisations YES ☐ NO ☐

7	**Which a vaccination has your child had?**				
Age	**Immunisation**	**Date (DD/MM/YY)**	**GP Surgery**	**Private**	**Abroad**
2 months	1st Diphtheria, Tetanus, Pertussis		☐	☐	☐
	1st Polio		☐	☐	☐
	1st HIB		☐	☐	☐
	1st Pneumococcal Vaccine		☐	☐	☐
	1st Rotavirus		☐	☐	☐
	1st Meningitis B		☐	☐	☐
3 months	2nd Diphtheria, Tetanus, Pertussis		☐	☐	☐
	2nd Polio		☐	☐	☐
	2nd HIB		☐	☐	☐
	1st Meningitis C		☐	☐	☐
	2nd Rotavirus		☐	☐	☐
4 months	3rd Diphtheria, Tetanus, Pertussis		☐	☐	☐
	3rd Polio		☐	☐	☐
	3rd HIB		☐	☐	☐
	2nd Pneumococcal Vaccine		☐	☐	☐
	2nd Meningitis B		☐	☐	☐
12 months	Hib/Men C Booster		☐	☐	☐
	3rd Meningitis B		☐	☐	☐
13 months	MMR (Measles, Mumps, Rubella)		☐	☐	☐
	3rd Pneumococcal Vaccine		☐	☐	☐
3½ to 5 Years	MMR Booster (Measles, Mumps, Rubella)		☐	☐	☐
	Pre-School Booster Diphtheria, Tetanus, Pertussis & Polio		☐	☐	☐
13-18 Years	Booster Diphtheria, Tetanus & Polio		☐	☐	☐
	1st Meningitis A		☐	☐	☐
	Meningitis C		☐	☐	☐
	1st Meningitis W		☐	☐	☐
	1st Meningitis Y		☐	☐	☐

Dear patient,

If you are registered with a GP practice in England, you will already have a Summary Care Record (SCR), unless you have previously chosen not to have one. It will contain key information about the medicines you are taking, allergies you suffer from and any adverse reactions to medicines you have had in the past.

Information about your healthcare may not be routinely shared across different healthcare organisations and systems. You may need to be treated by health and care professionals who do not know your medical history. Essential details about your healthcare can be difficult to remember, particularly when you are unwell or have complex care needs.

Having a Summary Care Record can help by providing healthcare staff treating you with vital information from your health record. This will help the staff involved in your care make better and safer decisions about how best to treat you.

You have a choice

You have the choice of what information you would like to share and with whom. Authorised healthcare staff can only view your SCR with your permission. The information shared will solely be used for the benefit of your care.

Your options are outlined below; please indicate your choice on the form overleaf.

- **Express consent for medication, allergies and adverse reactions only.** You wish to share information about medication, allergies for adverse reactions only.

- **Express consent for medication, allergies, adverse reactions and additional information.** You wish to share information about medication, allergies for adverse reactions and further medical information that includes: your illnesses and health problems, operations and vaccinations you have had in the past, how you would like to be treated (such as where you would prefer to receive care), what support you might need and who should be contacted for more information about you.

- E**xpress dissent for Summary Care Record (opt out).** Select this option, if you **DO NOT** want any information shared with other healthcare professionals involved in your care.

If you chose not to complete this consent form, a core Summary Care Record (SCR) will be created for you, which **will** contain only medications, allergies and adverse reactions

You are free to change your decision at any time by informing your GP practice.

8	**Summary Care Record Consent**			
	Having read the above information regarding your choices, please choose one of the options below **Yes – I would like a Summary Care Record** ☐ Express consent for medication, allergies and adverse reactions only. **Or** ☐ Express consent for medication, allergies, adverse reactions and additional information. **No – I would NOT like a Summary Care Record** ☐ Express dissent for Summary Care Record (**opt out**).			
	Patients name:		Date of birth:	Patient postcode:
	Surgery name:		Surgery location (town):	
	NHS number (if known):			Date:
	Signature:			
	If you are filling out this form on behalf of another person, please ensure that you fill out their details above; you sign the form above and provide your details below.			
	Name:			
	Please circle one:	Parent	Legal Guardian	Lasting power of attorney for health and welfare

For more information, please visit https://www.digital.nhs.uk/summary-care-records/patients, call NHS Digital on 0300 303 5678 or speak to your GP Practice.

9	**Required Information**	
	Name of parent/s:	1. 2.
	Name of person with legal parental responsibility:	
	Name of school attended:	

10	**Parent / Guardian permission given**	
	Permission given for someone other than a Parent/Guardian to accompany your child to an appointment?	
	Name of person/s: Relationship:	Parent / Guardian Signature:

11	**Signature**	
	Parent/Guardian signature:	Date:

Thank you for completing this form

For more information about the services we offer, please refer to our practice leaflet

Or see our website

Office use Only

To update the patient's consent status, use the SCR consent preference dialogue box and select the relevant option or add the appropriate read code from the options below.

Summary Care Record consent preference	Read 2	CTV3
The patient wants a core Summary Care Record (express consent for medication, allergies and adverse reaction only)	9Ndm.	XaXbY
The patient wants a Summary Care Record with core and additional information (express consent for medication, allergies, adverse reactions and additional information)	9Ndn.	XAXbZ
The patient does not want to have a Summary Care Record (express dissent for Summary Care Record – opt out	9Ndo.	XaXj6

Registration Checklist

NOTE: Please ensure all relevant sections below have been completed by the registration clerk at the time of registration

Section:	Notes	Read Code	Staff member that completed section
Section 1	Ensure Name and Date of Birth of patient has been completed		Completed by:
	Task to Debbie to activate SMS consent via MJOG		Completed by:
Section 2	Task to Debbie to add notes if patient is a carer or cared for		Completed by:
	If child has named social worker then please add name and contact number to patient home page		Completed by:
	If the child is a "looked after child" then please add the relevant read code to the patient notes	XaXLt	Completed by:
	If the child is under a Child Protection Plan then please add the relevant read code to the patient notes	YA804	Completed by:
Section 3	Religion and Ethnic origin		Completed by:
Section 4	Has patient been setup for online services and provided with log in details		Completed by:
Section 5	Electronic Prescription Service		Completed by:
Section 6	Medical Background		Completed by:
Section 7	Vaccination record		Completed by:
Section 8	If patient has consented for Summary Care record to be shared - action this.		Completed by:
Section 9	Required Information I.E. name of parent, school		Completed by:
Section 10	Parent/guardian permission		Completed by:
Section 11	Signature		Completed by:
Read Code	Ensure read code for - Informing patient of named accountable general practitioner has been added.	Xab9D	Completed by:
Read Code	Ensure read code for - Patient allocated named accountable general practitioner has been added.	XacWQ	Completed by: